On the Psychogenesis of Homosexuality

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Abstract

The best-established facts in relation to homosexuality point to developmental-psychological, not genetic or physiological, causation. The efforts of the last few decades to find evidence to support a biological theory have made it more doubtful than ever that such evidence will be found. In contrast, many studies have shown that the most significant factor which correlates with homosexuality is "gender nonconformity" or same-sex peer isolation. Another factor closely associated with homosexuality is an imbalance in parent-child interaction, notably forms of over-influence of the opposite-sex parent in combination with a deficient relationship with the same-sex parent. The third well-established correlation is with inherent, rather than discrimination-produced, "neuroticism" or emotional instability/immaturity.

Structured around this pivotal evidence from statistical as well as clinical research, homosexuality is explained here as a character neurosis. Characteristics of this neurotic character syndrome include personality immaturity, self-victimization, and self-centeredness. This syndrome affects not only the emotional but also the moral and spiritual dimensions of the psyche and if indulged leads to generalized personality deterioration. Therapeutically, a holistic approach, simultaneously addressing the emotional, moral, and spiritual components of the psyche, offers the best opportunity for overcoming homosexuality. De-egocentrization and personality maturity, including the development of mature manhood/womanhood, are the goals of therapy.

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The two currently prevailing opinions on the causes and dynamics of homosexuality[1] are first, that they are "genetic," and second, that they are "still unknown, but probably inborn." Both views have been advocated for some decades now by the proponents of the gay ideology, supported by a stream of like-minded ideas and interpretations in professional periodicals. These views have penetrated everywhere, including the Christian and academic world. They serve as the pseudo-scientific rationale for the successful "discrimination" argument. For there is a strong belief that if some people are just "that way" by their biological makeup, it would be unjust to deny them "equal rights," and inhumane to expect them to suppress their nature or try to change. By and large, however, we are confronted with a modern mythology masquerading as science.

In reality, primary, efficient causes of same-sex attraction (SSA), inclusive of homosexual pedophilia, have not been found and are very unlikely ever to be found in the field of "biology." Overwhelming evidence points to "psychology," namely, to the person's psychological life history, his childhood and adolescent experiences, and his family and peer relationships. Before perusing this evidence, we must critically inspect the arguments and observations adduced for a presumed biological causation; for as long as this deep-seated belief (that in its present form dates from the nineteenth century[2]) prevails, the whole issue of homosexuality remains clouded in ignorance and darkness. And this biological argument creates a climate which favors the fallacies of the gay ideology with their detrimental effects on many individuals with homosexual propensities and on public morality. Disconcertingly, most institutional science and most academic publications on SSA follow this ideology. Not a few of the prominent researchers are themselves gay activists, several of them openly professing their wish to prove the normalcy of the condition.[3]

Over fifteen years ago, a lesbian activist cautioned: "We should be aware of the potentially pernicious intermingling of gay activism with science, which produces *more propaganda than truth*."[4] In other words, people are misled. There are laudable exceptions, but the situation today has not improved. Much public and private research money is spent on studies that are thought to be potentially useful to the international undertaking to socially normalize same-sex behavior and relations. The intensified search for physical correlates of SSA during the last decades must be seen in this light. The general trend is to interpret and present the findings one-sidedly as supportive of the wished-for biological causation; psychologists and social psychologists try to demonstrate the normalcy of homosexual relations and gay parenting.[5] By contrast, research and publications at variance with the normality view are virtually tabooed at universities and research institutes and unwelcome with most professional journals and publishing houses.

Logically, if SSA—or for that matter, pedophilia—were determined by genetic or physiological variables, that would not make these orientations more normal or natural. Such false logic however is regularly

implied in the propaganda for normalization of same-SSA. Thus the sense of what is biologically healthy and normal (and morally good) in relation to sexuality becomes obfuscated and the justifications for sexually abnormal behavior (both in frequency and in risks to medical and psychological health) grow ever more absurd. Consider this example: a brochure "for boys and men" by the German governmental *Agency for Health Education* reveals, "Officially, the anus is not counted among the sexual organs, but actually it should be. At the anus very many nerves end which can easily be pleasurably stimulated. . . . One may also count the anus as belonging to the category of sexual organs since many homosexual and also heterosexual people practice anal intercourse. . .that can be very exciting for both partners."[6] This is abnormality "normalized" by pseudo-biological argumentation.

Paradoxically, contrary to what is generally suggested and widely believed, perusal of the research in the fields of "biology" and psychology leads to the following conclusions: (1) No hard evidence for the existence of genetic or otherwise "biological" causes of homosexual tendencies has been found. (2) "Indications" of physical correlates reported in some publications either turned out to be "one-day butterflies" which could not be confirmed in subsequent investigations or may equally or better fit a psychological explanation. (3) There is a well-established and consistent body of evidence pointing to psychogenic, not physical, origins. A brief survey may elucidate this assessment.

In their classic 1993 survey of the research on homosexuality and "biological" (physical) factors, W. Byne and B. Parsons concluded that "there is no evidence. . .to substantiate a biologic theory."[7] Sixteen years and many studies later, that conclusion was unaltered: "It is not an exaggeration to say that our understanding of the biological underpinnings of homosexuality has not progressed much."[8] The history of the quest for *hormonal* peculiarities of same-sex attraction is a case in point. Time and again some "promising" correlate has been reported, but invariably it turned out to be a sample-specific artifact that could not be found in other samples.[9] Byne states: "Attempts to prove that gay men have feminized gonadotropin responses were made decades after strong evidence suggested that the brain mechanism regulating the response does not differ between men and women." He also says, "It required 25 studies to convince some that testosterone levels in adulthood do not reveal sexual orientation."[10] And regarding the periodically resurfacing idea of sex-atypical prenatal hormone peculiarities in homosexuals that would generate sex-atypical brain structures: "It is [already] difficult, if not impossible, to relate sex steroids in a consistent way to the anatomical differences of the brain between the sexes," let alone to hypothesized brain differences between homosexuals and heterosexuals.[11] This is apart from the fact that the prenatal hormonal hypothesis for homosexuality itself is not only purely speculative but also very improbable.[12]

As for *genetic factors*, current speculations and investigations hardly focus on genes for homosexuality *proper,* but rather on hypothetical *predisposing* factors of a *non-sexual* nature. This silently acknowledges that the decisive factors producing SSA are not genetic but "environmental," in the broadest sense of the word, from the intrauterine to the (childhood and adolescent) psychological environment. No biologic environmental factor has been well established, but indeed several psychological background factors have. *Twin research* in particular has virtually debunked the myth of genetic causation. This is a fascinating story in itself. In 1952, F.J. Kallmann reported 100 percent concordance for homosexual propensities in a male volunteer sample of monozygotic twins, against 11.5 percent or 42.3 percent in dizygotics, depending on the definition of homosexuality.[13] (Incidentally, this definition is a tricky factor in homosexuality research.) Compare this to later numbers: homosexuality-concordance percentages of between 25 and 66 for groups of male and female monozygotic pairs, against around 20 percent for dizygotic pairs.[14] Of non-twin brothers of male homosexuals, 9 percent as well as 11 percent adoptive brothers were also homosexual.[15] So logically, "the fact that biological brothers and adopted brothers show the same incidence of homosexuality strongly suggests that it is entirely environmental in origin."[16]

There is more. Monozygotic concordance for SSA proves very low in studies with samples that are not self-selected (convenience or "snowball samples") such as those above. Only 3 out of 27 monozygotic male pairs from the Australian twin register were concordant for SSA (11 percent), versus 0 out of 16 same-sex dizygotic pairs and 2 of 19 opposite-sex dizygotic pairs (12 percent). Of 22 female monozygotic pairs, 3 (14 percent) were SSA-concordant, versus 0 of 16 same-sex dizygotic pairs and 2 of 19 opposite-sex dizygotic pairs (12 percent).[17] From the respondents in a recent study of the Swedish twin registry (the largest in the world), 7 male monozygotic pairs were concordant for SSA, 64 discordant (thus 10 percent monozygotic concordance), against 3 concordant male dizygotic pairs and 50 discordant (thus 6 percent dizygotic concordance). For women, monozygotic concordance was 12 percent, dizygotic concordance 9 percent.[18] In sum, monozygotic concordance appears lower in proportion as the samples become more representative of the general population; thus the discrepancy between the more recent samples and the older ones is mainly due to selection procedures. Clearly, concordant monozygotic pairs were over-represented in the older volunteer studies.[19] Besides, zygosity determination has sometimes been inaccurate because looking alike is not decisive; only blood testing is[20] (and even twin-registry samples are not safeguarded against this over-representation of homosexuality-concordant monozygotic pairs). Add to this that it is ultimately still a minority of all registered twins who participate in a study like this and whose responses are useful (e.g., a mere one third in the Swedish study).

In sum, the genetic hypothesis has become most unlikely. To salvage it, so-called model-fitting formulas which yield "heritability coefficients"

have been applied to some twin data, but it looks like "statistical massage" because the results are one-sidedly presented as indicative of genetic influences, whereas the alternative "environmental" explanation is ignored. (Later publications carelessly cite such prejudiced earlier publications as having demonstrated the genetic factor). Model fitting assumes, for instance, that the (small) differences in SSA concordance between monozygotic and dizygotic pairs indicate genetic influences—precisely the thing that has to be demonstrated. Ignored are interpretations based on psychological observations regarding the development of self-identity in twins.[21] In reality, these "heritability coefficients" are *not* measures of genetic influences but rather estimates of the strength of genetic influences *if they would exist*.[22]

But the *psychology of twins* offers the most plausible—and verifiable—insights. Twins may identify intensely with their co-twin, want to be and act like their *alter ego*, in particular when they are treated by parents, siblings, and peers as "identical." Hence the behavior, likes, and dislikes of one may duplicate the other's unto the smallest details. Understandably, this mutual identification/imitation may be stronger in monozygotic than in dizygotic twins, and stronger in dizygotic twins than in non-twin siblings. The other important twin phenomenon is just the opposite, viz., overemphasis of their differences, often as an effect of their parents' (and the environment's) doing so. In their constant mutual self-comparison, they may accentuate the points that distinguish them as an individual in their own right. That may lead to an inferiority complex in the one who comes to see himself (herself) as the less valued of the two. Furthermore, one twin may bond more strongly with the mother, the other with the father (these things may be related).[23]

Interestingly, precisely such distinguishing factors are encountered in the childhood (adolescence) of monozygotic twins discordant in homosexuality; and they provide a clue as to its psychogenesis. For homosexually inclined monozygotic twins with heterosexual co-twins—about 90 percent of monozygotic twins are discordant for SSA—the former appear to be more "gender nonconforming" in childhood, i.e., less boyish or girlish, as compared with their co-twin.[24] This gender *nonconformity* of one versus the gender *conformity* of the other suggests an inferiority view of the first—the weak one versus the strong one. Fifty years ago, this was the sad theme of an apparently autobiographical novel by Morris West, then popular in Catholic circles. Central was the tragedy of the homosexual Nicholas Black, who was, or rather saw himself as, the inferior shadow of his heterosexual twin brother. It nicely illustrates how the typical gender-inferiority complex of men with homosexual interests can develop as a result of self-comparison with a close brother (or other boys, for that matter—see below) and is therefore worth citing at some length:

> From the beginning, he had been cheated: the hidden fetal beginning when the determinant elements were doled out by whatever

> power decided that, out of the blind coupling of man and wife, there should grow a parody of a man. He had been born a twin—identical in face and form with the brother who preceded him by an hour out of the womb. He had been born a Catholic. . . . But here the identity ended and the slow division began. The firstborn grew swart and strong, the second was wan and sickly. They were like Esau and Jacob—but Esau enjoyed the birthright: the field sports, the fishing, the long rides in the dappled summer, while Jacob clung to the shelter of the house and safe harbor of the sewing room and the library. At school he lagged behind, was a year late at Oxford; and while his twin was off with a gunnery commission in the Western Desert, he was confined to a hospital bed with rheumatic fever. All the strength was within the one; all the weakness in the other. All the maleness belonged to the firstborn, and in Nicholas Black there was only an epicene beauty, the soft subtlety of a mind turned back too long upon itself."[25]

The search for a *genetic link* for SSA has not yielded substantial evidence either. The first, widely published, study of D.H. Hamer et al. (1993) was a tempest in a tea cup.[26] The verdict by the famous French geneticist Jerome Lejeune that its methodological defects were so serious that "were it not for the fact that this study is about homosexuality, it would probably never have been accepted for publication"[27] proved correct. An unconvincing replication by a research team led by Hamer[28] was followed by a clear failure to replicate it with a larger Canadian sample.[29] Nor do pedigree findings fare any better for the theory of biological causation. The same Hamer acknowledged, "We never found a family in which homosexuality was distributed in the obvious pattern Mendel observed." Referring to the finding of a higher correlation in SSA between lesbian women and their mothers than between them and their sisters, he commented: "The rate was a whopping 33 percent, meaning that the daughter of a lesbian had a one-in-three chance of also being a lesbian. Genetically speaking, this result was impossible."[30] This type of conclusion is however slow to penetrate. With few exceptions, findings such as a somewhat elevated occurrence of male SSA among maternal relatives (otherwise, still not confirmed),[31] or the slightly higher frequency of older brothers among homosexual than heterosexual men[32] have been presented as support of an *ad hoc*—and most complicated—physiological theory, despite the existence of a simple and straightforward explanation based on psychological observations. More examples of reportedly "genetic indications" for homosexuality from the last decade of research could also be given.

Nor have *neuroanatomical* correlates of SSA been demonstrated, despite a few invalidated suggestions to the contrary. For example, an initial report of larger inter-hemispheric fiber bundles in SSA men could not be replicated.[33] LeVay (1991) reported a smaller hypothalamic nucleus (INAH3) in SSA men who had died of AIDS than in heterosexual male drug users.[34] Allegedly, this was evidence for a feminized brain

center in homosexual men, but several more trivial explanations could not be ruled out. Ten years later, Byne found a non-significant smaller ratio of INAH3 volume to brain weight in homosexual men who had died of AIDS than in deceased heterosexual male drug users, but the nuclei of both groups contained the same number of neurons.[35] The brain weight data may reflect the superior health care received by the homosexual men or variations in autopsy and fixation procedures, as the groups came from different hospitals.[36] The equal number of neurons in both groups is interesting because INAH3 might be one of very few human brain-anatomical structures for which sexual dimorphism has been reasonably demonstrated.[37]

Also, many *brain function* studies with SSA persons are subject to prejudiced biological interpretations—and publicity. For example, sex-atypical functional hemispheric asymmetry and connectivity findings, such as those reported in one study,[38] even if they would be replicated, may be accounted for by various factors other than inherent differences in brain structures or functions between homosexuals and controls (e.g., factors of attention and psychosocial conditioning). Methodologically, any incidental correlation in the field of the "biological" and behavioral sciences—such as between some neuro-anatomical, neuro-functional, or other physical factor and homosexuality—should first be confirmed in a series of replications, in different samples and by independent researchers, before it can be regarded as reasonably established. Further, in the theoretical case of a proven physical correlate of a behavioral trait such as homosexuality, it does not logically follow that the physical variable is a cause, nor even a disposition that would *of itself* facilitate or catalyze homosexual development. Such a correlate might as well be the biological basis of some physical or temperamental peculiarity which in itself is unrelated to sexual orientation but only *indirectly* predisposes to it, depending on a) the reactions of the child's environment to that peculiarity or b) the child's self-perception or self-image with respect to it.[39] But again, physical determinants of SSA have not been demonstrated, any more than for homosexual or heterosexual pedophilia. Dante had it wrong. There is no reason to think that homosexual people are handicapped by "badly put up nerves," *mal protesi nervi*.[40]

The observation that the homosexual twins of monozygotic pairs with heterosexual co-twins had more *gender nonconformity* interests and behaviors than their co-twins,[41] as we saw illustrated in the case of Nicholas Black, leads to a discussion of the importance of the *peer factor* in the psychogenesis of homosexuality. For this, gender nonconformity cannot be explained genetically or hormonally (in view of the absence of evidence for hormonal abnormalities in persons with SSA). Significantly, it is this childhood and/or adolescent peer factor that has proven to be statistically the most closely associated to male and female homosexuality, more than anything else. There is an unbroken record of replications of this phenomenon in all kinds of samples, clinical and

nonclinical, in various countries and cultures, and for over half a century.[42] Therefore, logically, any theory of SSA should take it as a starting point.

What exactly is meant by "gender nonconforming" interests and behavior? The terminology suggests attitudes normally displayed by the opposite sex, thus feminine tendencies in men with SSA, and masculine tendencies in women. That explanation is only partly adequate, though. It is true that many people with SSA show a degree of cross-gender attitudes,[43] a minority even to a high degree.[44] Yet upon inspection of the traits composing the gender-nonconformity factor, "it may be [in the case of the pre-homosexual boy] the *absence of masculine traits* rather than the *presence of feminine* traits that is the stronger and most influential variable for a future homosexual orientation in adulthood."[45] Invariably, the most distinguishing items characterizing "gender nonconformity" for pre-homosexual boys are the following: "did not participate in baseball/soccer," "avoided physical fights," "afraid of physical injury," "not daring."[46] Thus for pre-homosexual boys, the common denominator of these symptoms of unmanliness or unboyishness can best be described as "non combativeness," "softness," "feeling a weakling," "masculinity avoidance."[47] For pre-lesbian girls, the situation is comparable. A degree of "tomboyishness" characterizes the majority of them, yet only a minority of girls known as tomboys develops lesbianism.[48] The core trait of gender nonconformity in pre-lesbian girls, as in adult lesbian women, is more adequately described as underdeveloped femininity—deficient feminine "softness," "weakness"—or lack of feminine self-confidence, i.e., femininity-avoidance rather than "masculinity" as such.[49] Particularly relevant for the understanding of the development of same-sex tendencies is the universal observation that these gender nonconforming pre-homosexual children and teens very frequently were, and above all, *felt as if they were*, outsiders in their same-sex peer group. Pre-homosexual boys were "lone wolves," could not cope with other boys, and had few friends.[50] And "the plight of many lesbians was that so few could find real friends [around puberty]."[51] The crucial experience of *not belonging* to the world of same-sex peers is traumatic. It engenders the self-view of *gender inferiority* and accompanying feelings of loneliness and *distress* or *grief*. In early adolescence and adolescence, this not belonging fuels a *longing to belong* to the same-sex community. And this may give rise to homo-erotic friendship fantasies.

Un-masculinity, lack of combativeness, "softness," etc. in boys and a deficient identification with femininity in behavior and/or self-view in girls are *habits* of behavior and thinking which often, not always, originate at home, especially as effects of *upbringing* and *parent-child interactions*. This can be deduced from the second-largest statistical correlation between SSA and childhood/teenage factors (the aforementioned "peer factor" being the largest), viz., the association between SSA and parental factors, in particular in regard to the same-sex parent.[52]

The great majority of men with SSA report childhood emotional distance from their father, and/or disturbed father relationships or paternal absence, at any rate, as well as a lack of father-son confidentiality and of positive paternal influences. As a rule, this "psychologically absent" father figure co-occurred with maternal over-influence, likewise in many variants: over-possessiveness, over-anxiousness, over-protection, doting, over-indulgence, over-interference/control, favoring, pampering, infantilizing or babying, clinging to the son, treating him unwittingly as the girl she had preferred in his place,[53] and the like.

These two parental factors are typical of the boyhood of most men with SSA in the Western world and—perhaps with some variations[54]—also in non-Western cultures.[55] But it is a modal picture which certainly does not account for all cases. For example, some fathers behaved like overprotecting mothers; in other cases, both parents were overprotective. Some men with SSA had older parents (for instance, one of the younger children of a larger family), while some were brought up by their grandparents, and others by adoptive parents. The net effect of such parental upbringing was insufficient behavioral and mental masculinization and/or inhibition of boyishness and maleness. Habits were formed such as physical fearfulness, over-sensitivity, lack of firmness, softness to self, lack of initiative, submissiveness, over-docility and primness, over-domesticated behavior, infantility and naivety, behavioral inhibition, or narcissism and superiority ideas. Relatively many pre-homosexual boys were overly influenced by, attached to, or dependent on their mother, imitating her behavior and attitudes (although this does not necessarily imply affectionate closeness), whereas the father did not play much of a role, or was perceived as rejecting.

Parental influences on pre-lesbian girls often discouraged feminine habits, interests, and roles. The motherly element may have been too weak, the pressure to "achieve," behave "strongly," suppress their softer side, disproportionately strong. For example, the girl may have been too much her father's comrade, the father too prominent in her education while the mother was hardly involved, or the father was not much interested in her as a girl, or not affectionate, or neglectful in other ways. In short, the boy was not sufficiently viewed and treated as "a real boy," the girl not sufficiently valued as "a real girl." In some cases, there was a measure of parental role reversal. Relatively many parents had emotional problems or were emotionally imbalanced, and many marriages were not happy.[56] Thus, objectively, pre-homosexual children often were the unintended victims of their parents' personality and relational problems. It may be noted that the love of parents who overly attach a child to themselves is often more self-directed than child-directed (the bond of Marcel Proust [1871–1922] with his mother is a classic example). These children may have felt lonely and not understood despite their parents' affection. In any case, the majority of pre-homosexual children and youngsters have missed a healthily affectionate and cheerful home atmosphere.

With few exceptions, the above parental factors do not directly *cause* SSA but, if they go together, *predispose* to it. For instance, the psychologically absent, distant, or rejecting father also figures prominently in the childhood of (non-homosexual) male delinquents,[57] and many adult men today missed their father without ever becoming homosexually interested.[58] Parental (and other) upbringing habits are predisposing insofar as they generate traits of un-manliness (in boys) and un-femininity (in girls). These in turn hamper a child's coping with the same-sex world, particularly in the critical phase of pre-adolescence. Youngsters compare themselves to others, in the first place with same-age, same-sex peers. Gender-nonconforming behaviors and interests are easily felt as "being different," which is virtually identical with "being inferior," for one of the most powerful psychic instincts is the need to be like the others, be one of them, *belong* to them.

In addition to parent-child factors, experiences with peers may catalyze feelings of gender inferiority or gender non-belonging. For example, the adolescent may self-compare with a brother or sister who is "quite the opposite of me"[59] (as Nicholas Black compared himself negatively with his twin brother). Being or feeling rejected, bullied, or teased by siblings or same-sex peers is another particular instance of this.[60] The child's place in the rank order of siblings may be important, as in the earlier mentioned case of pre-homosexual boys with older brothers. Predisposing factors reinforce one another. One client with SSA who had been mother's favorite and had suffered from the contempt of his older, and in his eyes more robust, brothers, summarized his self-view: "The weakest hen in the chicken run is always picked (on)."[61]

A different category of factors predisposing to gender-inferiority feelings—operating together with predisposing parental attitudes—involves illnesses and handicaps, physical or psychological. These may include the effects of minimal brain lesions, asthma (stimulating overprotection), deafness, squinting, stuttering, clumsiness, a skin disease, a harelip, fatness or meagerness, tallness and smallness, and irregularity of facial traits. (It is no wonder if some girls with semi-masculine genitals develop a femininity-inferiority complex, and then perhaps lesbian interests). Among lesbian women, "ugliness complexes" regarding the feminine qualities of their body are not uncommon; for the value of feminine graciousness and beauty rank high in the community of teenage girls.

The periods of pre-adolescence and adolescence are crucial for the development of SSA. Before these phases, children may display "gender nonconforming" traits, but it must be emphasized that there are no "gay" children. (This is an irresponsible, stigmatizing myth.) The first adolescent homo-erotic feelings or fantasies spring from a painful sense of gender inferiority and not belonging.[62] Such feelings may still be outgrown, but strike deeper roots, if these inferiority feelings intensify and become an inferiority *complex*.[63] Feeling inferior, not valued, locked out, and lonely spontaneously triggers feelings of depression and grief. This is

grieving over the self, the ego, and may develop into self-pity. Because of their inherent self-centeredness, self-importance, and perception that they are the center of the world, the self-pity of children and adolescents can be described as *self-dramatization*: "I am only . . . poor me."[64] Like receiving pity (consolation), self-pity (self-consolation) is a defensive reaction intended to overcome traumas and hurts of the self. It easily becomes an autonomous habit, however, when indulged in for a longer period. For without help, it is most difficult for a young person to suffer without self-pity and rebelliousness, i.e., to truly *accept* real or imagined inferiorities, injustice, rejection, or a humiliating situation. Once habitual, the poor-me attitude—inner self-dramatization, self-victimization, revolt, anger—and associated over-compensatory reactions, such as exaggerated self-affirmation, the seeking of recognition, attention, and same-sex affection, become like a second nature, a second personality, "an inner child (or adolescent)". A pathetic teenage "me" revolves around itself and its unfulfilled longings for compensatory same-sex affection, belonging, and recognition. Yet striving to satisfy them does nothing to diminish or "repair" the underlying sorrow and chagrin; to the contrary, gratifying these longings increasingly brings or keeps the person in bondage to the frustrated ego of his teenage years. Homoerotic interests are not uncommon during adolescence, when the awakened sexual instinct has not yet found its definitive, natural object. Developmentally, adolescents must first experience that they belong to the world of their own sex, and confidently identify with their own sex, before they (can) become sensitive to the appeal of the opposite sex. Teens look up to same-sex models and want to imitate them. Teenage girls may rave over a charming teacher or—generally somewhat older, already more developed—girls who carry the show (and are popular with boys). Boys look up to (mostly older) boys and young men with a high masculinity status (and who are popular with the girls). Teens who feel pitiable and inferior as to their masculinity/femininity admire their same-sex idols all the more in proportion to the pain they feel from missing what the others seem to possess. They *crave for* such a friend and his manly (or her feminine) affection, however, in the way of an unrealizable daydream, like a child living in poverty might dream of becoming rich. The emotional undercurrent is loneliness, the self-drama of not belonging to the world personified by their idol. Such teens shut themselves up in the private world of impossible, wishful fantasies. In (pre-)puberty such hankering for warmth gets erotic overtones, and grows even deeper roots if acted out in masturbation fantasies.

This mental state has several implications. In consequence of a fixation in *adolescent self-centeredness* and selfishness, emotional maturation is more or less severely hampered, for psychic maturity depends on the process of the young person's de-egocentrization. Connected to this, the core of homosexual love is immature self-love; the friend/partner must love *me* before anything else. That is part of the explanation of the instability and utopian character of homosexual affairs.[65] The homosexual

desire is insatiable, fickle, self-directed, and not person-directed.[66] The more it is indulged, the deeper the dissatisfaction, as with other sex addictions.[67] The teenage fixation is also apparent in the "partner ideal," which is the same one as dreamed up in (late) adolescence. In the majority of cases, the inferior-feeling teenager becomes obsessed with a same-sex adolescent or young adult with the physical and personality traits painfully missed or perceived as lacking in himself (herself).[68]

This "formula of attraction" underlines the basic self-centeredness of same-sex fascinations. What is admired and sought in the preferred partner is inspired by the person's inferiority feelings (muscularity, beauty, large penis, popularity, boyish mischievousness, "macho" clothes in the case of men; traits of feminine softness, graciousness in the case of women). "Steady" affairs are characterized by the emotional swings from euphoria to depressive disillusion that are typical of adolescence. Lesbian relationships "involve more of a symbiotic relationship, a closeness suggestive of almost mystical oneness. . . . [This is] illustrated by the large proportion of Lesbians who feel devastated. . .at the abrupt termination of a close relationship, felt to be like the wrenching apart of Siamese twins."[69]

Secondly—after self-centeredness—since the inner teenage self is a frustrated personality (viz., an inferiority complex with inherent feelings of self-pity and unfulfilled passionate longing), SSA is the fruit of *neurotic development*. One instructive illustration is this: of 17 men with SSA who did not feel feminine, 13 (76 percent) "reported chronic, persistent terror of fighting with other boys during the juvenile and early adolescent period . . . [and] that painful loss of self-esteem and loneliness resulted from their extreme aversion to peer-aggressive interactions. All but one were chronically hungry for closeness with other boys . . . and these were labeled 'sissies' by peers. . . . None engaged in even the modest juvenile sex-typed interactions described by the least aggressive heterosexual youngster."[70] That sense of male (female) non-belonging, including the "closeness" hunger, becomes a mental habit. That is why the well-established correlation between homosexuality and so-called neuroticism (neurotic tendencies, emotional instability) cannot be attributed to social discrimination,[71] the inevitable explanation of those who have difficulty in accepting the intrinsic pathology of SSA. Emotional distress in reality is prior to, and brings about, the first same-sex attractions. Three sources of evidence indicate the "neuroticism" of SSA: a) The elevated scores on neuroticism (N) tests, i.e., on those few adequately standardized and validated questionnaires such as H.J. Eysenck's Maudsley Personality Inventory (MPI) and Eysenck Personality Inventory (EPI),[72] and some scales of R.P. Cattell's Sixteen Personality Factor Questionnaire (PF)[73] and of the Minnesota Multiphasic Personality Inventory (MMPI).[74] These tests give the best estimates of neurotic emotionality, comparable to standardized intelligence tests. Neuroticism tests do not measure social discrimination.[75] b) Studies on lifetime SSA-

concomitant psychopathology: on anxiety and depression,[76] on suicidal attempts related to same-sex relationship conflicts,[77] on compulsive partner seeking and impaired capacity of bonding,[78] on prevalence of sexual dysfunctions[79] and "domestic violence"[80] in "steady" partnerships, and on drinking and substance abuse.[81] c) Biographies and autobiographies of persons with SSA invariably picture a life burdened by above-average emotional pathology from youth on, most conspicuously if the person embraced a gay lifestyle.[82]

In sum, much evidence supports the view of SSA as a sexual neurosis based on character malformations in childhood. In the old but apt terminology: a *character neurosis*. After all, the pre-revolutionary (pre-1973) definition in the Diagnostic Manual: "arrest of emotional development," although not very precise, was a lot better than the later formulations which at least suggested born-that-way interpretations and therefore meant a regression to the ignorance of the nineteenth century, when the primary causes of most psychopathology were thought to be inherited peculiarities of the brain.[83] In fact, the homosexual character neurosis, inclusive of homosexual pedophilia[84] and probably also much of what is called transsexualism,[85] is a syndrome of interrelated components: a gender *inferiority complex,* underdeveloped masculine/feminine *personality habits*, *emotional immaturity*, and excessive *self-centeredness*.

Regarding the neurotic aspect, the aforementioned tendency to self-pity or self-dramatization may propel a generalized tendency to discontentedness, negativism, grumpiness, i.e., *complaining*, whether or not openly expressed. At times, the term "complaining illness" is quite appropriate. This habitual complaining may be chiefly about psychic displeasure; worries, anxieties and irritations about the past and the future, oneself, one's life, or others; or about real and imagined physical and psychosomatic ailments. Feelings of contentment, gratitude, cheerfulness, and happiness tend to be minimized, overlooked, or undermined by the recurrent urge to feel the victim of some suffering or drama. This causes many unnecessary interpersonal conflicts and jealousies, as well as self-destructive (masochistic) behaviors. "Unresolved," chronic anger (with a parent, the outside world, fate, God), resentment, and indignation, which are twin reactions of self-pity, mostly originate in pre-adolescence and adolescence as well.[86] The inner need to complain about oneself, which is also typical of many neurotic syndromes other than SSA, feeds the longing for same-sex affection, as this is rooted in self-pity about not belonging.[87] Thus the person with SSA is inclined to suffer from "injustice collecting."[88]

Immaturity encompasses a wide range of mental and behavioral patterns, from infantile/pubescent attachments to the parents, to child-of-the-past behavior and thinking in areas connected with masculinity/femininity inferiority feelings, to homosexual fantasies and relationships proper. In part, a homosexual "is emotionally in his teens."[89] Looking back, ex-homosexual people sometimes verbalize the same self-insight.[90]

Neurotic and immature self-centeredness is most conspicuous in the lives of many who slide or hurl themselves—fatalistically or rebelliously—into a gay lifestyle. This eventually leads to a pervasive *personality deterioration*, emotionally and morally. The person risks becoming addicted to depersonalized lust; many narcissistically seek attention and veneration, become liars to themselves and others, and cheat their partners. The moral sense becomes dull; many lose their religious faith. Exterior appearances notwithstanding, joylessness, cynicism, and self-absorption may predominate the person's inner and private life.[91]

But is trying to *change* a realistic alternative? It is often argued that if change to full heterosexuality is not possible, it is meaningless and unnecessary self-torment to suppress one's same-sex desires. Mostly the corollary of this argument is that change is impossible anyway. This is however a wrong representation of the dilemma. The fundamental choice is between abandoning oneself to a neurotic and emotionally, morally (and medically) degrading lifestyle, and resisting such a lifestyle, whether or not the latter option will entail greater or smaller changes in sexual orientation. Sincere and sensible resisting, though, always brings at least some improvement, with regard to one's sexual attraction and in the overall mental condition. Because SSA is a character neurosis, the most adequate approaches of "resisting," therapeutic and otherwise, focus simultaneously on sexual behaviors and emotions, the underlying lack of male/female identification and self-confidence, and on the self-directedness and personality immaturity in which they are rooted. For the person who becomes less immature/self-centered will experience a proportional decrease in same-sex attractions and increase in mature manhood/womanhood. This said, the outlook for sexual change proper is not so bleak as it is generally thought. It is true that as yet, *complete* change, meaning the disappearance of all homosexual attractions plus the restoration of normal heterosexual attractions, is achieved only by a minority. But the majority still may succeed in reducing their same-sex interests, often substantially, and improve emotionally and with respect to other relevant personality aspects.[92]

Several reasons can be given for the limited success of therapeutic attempts. One is the lack of resolution to change—the factor of motivation and the weakness of the will of many concerned persons, in spite of their good intentions. Although they may wish to change, they still may cherish their fantasies and other personality habits. Another reason lies in the difficulty with overcoming deep-seated emotional and behavioral patterns, which requires perseverance and a certain toughness towards the self. And there are relatively few change-directed counselors, pastors, and therapists, and the anti-change propaganda is strong in the mental and medical health professions and the culture at large. Nevertheless it is unfounded that persons who want to change must be dissuaded from treatment or other resistance- or change-directed approaches because the radical-change rate is—still—modest. Following such fatalistic logic,

most attempts at overcoming disordered emotional and character habits, deeply engrafted neurotic syndromes, addictions, criminal tendencies, etc., of any kind should be abandoned on the ground that complete and lasting changes are only achieved in a minority of cases. Moreover, the science of SSA therapy is still young. In comparison with a century ago, we have more knowledge about the origins of disordered emotional and character habits, and there has been a positive development in treatment methods. A not negligible percentage of people with SSA asks for and will keep asking for change-oriented help, out of moral and religious motives or because their homosexual experience leaves them dissatisfied. If not discouraged by the prevailing pro-gay indoctrination, that number might well be 25 percent.[93]

Change is a holistic, psychological-moral-spiritual process. The person must get to know himself (herself) not only psychologically—including his (her) immature and neurotic side as described above—but also on a deeper level, morally: recognize his (her) moral weaknesses or vices—self-seeking and lack of love, lust enslavement, pride, insincerity, disproportionate self-love, lack of self-discipline, cowardice, discontentedness, revolt, and ingratitude. Next, he (she) must learn how to counteract these habits and reinforce their opposite. Therapeutic lead motives are the following: ego-centeredness and selfishness (lack of interest in others, lack of loving); how to resist same-sex behavior (including masturbation and pornography, among other things) and fantasies; gender inferiority feelings (versus masculine/feminine self-confidence); teenage thinking, feeling, and behaving; childish self-pity, self-dramatization, complaining, feeling wronged, blaming others; lack of awareness of one's daily duties and responsibilities; immaturity in relation to others, the parents, friends. Put more positively, it is *a battle* to grow in virtues while fighting the vices.[94] In this endeavor, the moral, spiritual, and religious dimensions of the psyche must be involved and activated: the soul's inherent need for God, its moral conscience and unconscious longing for moral purity, the healing powers of prayer, forgiving[95] and asking for forgiveness, and doing penance. As this holistic approach addresses the whole psyche and personality and not only a part, it opens up the best perspectives for change.[96]

At the same time, this holistic approach is the most civilized and humane. It is based on scientific insights and research, and on a realistic (i.e., not exclusively materialistic) view of the human psyche. It avoids on one side the errors of a shallow humanist-materialist view of man, with its blindness to the moral and spiritual dimensions of the soul, and its factual indifference to the emotional, medical, and moral miseries of people abandoned to the self-destructiveness of the homosexual way of life. On the other side, this approach is at variance with the primitive mentality, which although recognizing the unnaturalness and immorality of homosexual behavior and liaisons, reacts with merciless harshness toward those who may feel or act upon SSA.

Notes

[1] Definition: chronic same-sex attraction after age 17 or 18, accompanied by near-absence of or strongly reduced heterosexual attraction.

[2] The basic axiom of the psychiatry of Emil Kraepelin (1856–1926) that has inspired many theories not only of the psychoses, neurotic and sexual deviations, and delinquency, is twofold: the causes of most psychic aberrations are "biologic," ultimately founded in the brain, and (in general) genetic. The psyche was considered, implicitly or explicitly, a by-product or consequence of the material brain, where the "real" processes take place.

[3] Familiar names in this connection: Magnus Hirschfeld, Benjamin, Alfred Kinsey, S. LeVay, D.H. Hamer, J.M. Bailey, R.C. Pillard, S. Hershberger, M.S. Weinberg, B.S. Mustanski.

[4] Camille Paglia, *Vamps and Tramps* (New York: Vintage Books, 1994), emphasis added.

[5] Cf. the critique of the unsubstantiated claims of the American Psychological Association regarding the positive impact of gay parenting by Philip M. Sutton, "Dr. Sutton on the APA Task Force Report" (2011), http://narth.com/2011/01/dr-sutton-on-the-apa-task-force-report/.

[6] Bundeszentrale für gesundheitliche Aufklärung (Federal Centre for Health Education), *Wie steht's, wie geht's?* (*How are you?*) (2009), 40, http://www.medrum.de/content/wissenswertes-fuer-jungen-und-maenner.

[7] W. Byne and B. Parsons, "Human Sexual Orientation," *Archives of General Psychiatry* 50 (1993): 228–239.

[8] L.J. Gooren and W. Byne, "Sexual Orientation in Men and Women," in *Hormones, Brain and Behavior*, eds. A.P. Arnold et al. (New York: Academic Press, 2009), 2444.

[9] G.J.M. van den Aardweg, *On the Origins and Treatment of Homosexuality* (New York: Praeger/Westport, 1986), ch. 2; W. Byne, "Science and Belief: Psychosexual Research on Sexual Orientation," *Journal of Homosexuality* 28 (1995): 336 and 337; W. Byne, "Why We Cannot Conclude that Sexual Orientation Is Primarily a Biological Phenomenon," *Journal of Homosexuality* 34 (1997). See also P.S. Bearman and H. Brückner, "Opposite-Sex Twins and Adolescent Same-Sex Attraction," *American Journal of Sociology* 5 (2002): 1188 ff.

[10] Byne, "Science and Belief," 336, 337.

[11] Gooren and Byne, "Sexual Orientation in Men and Women," 2444.

[12] For instance, people with SSA do not have sex-atypical hormonal patterns. That SSA seems to occur more than on average among women prenatally exposed to high testosterone doses—although not in the great majority of cases (H.F.L. Meyer-Bahlburg, "Gender and Sexuality in Classic Congenital Adrenal Hyperplasia," *Endocrinology and Metabolism Clinics of North America* 30 (2001): 155–171)—does not directly bear on the causes of lesbianism; these women develop semi-masculine genitals (among other symptoms), whereas "ordinary" lesbians are physically normal. Moreover, such samples are likely to over-represent women with sexual anomalies. The psychological interpretation

of lesbianism in some such masculinized women lies near at hand: the girl is very likely to develop a feminine-inferiority complex (see below). The amazing thing is that the possibility of such an explanation is not even mentioned by most authors, suggesting that the psychology of people with physical defects and handicaps is unknown territory to them.

[13] F.J. Kallmann, "Comparative Twin Studies on the Genetic Aspect of Male Homosexuality," *Journal of Nervous and Mental Diseases* 115 (1952): 283–298.

[14] J.M. Bailey and R.C. Pillard, "A Genetic Study of Male Sexual Orientation," *Archives of General Psychiatry* 48 (1991): 1089–1096; M. King and E. McDonald, "Homosexuals Who Are Twins," *British Journal of Psychiatry* 160 (1992): 407–409; F.L. Whitam et al., "Homosexual Orientation in Twins," *Archives of Sexual Behavior* 22 (1993): 187–202; J.M. Bailey et al., "Heritable Factors Influence Sexual Orientation in Women," *Archives of General Psychiatry* 50 (1993): 217–223.

[15] J.M. Bailey and R.C. Pillard, "Genetics of Human Sexual Orientation," *Annual Review of Sex Research* 6 (1995): 126–150.

[16] T.R. McGuire, "Is Homosexuality Genetic?" *Journal of Homosexuality* 28 (1995): 139.

[17] J.M. Bailey et al., "Genetic and Environmental Influences on Sexual Orientation and Its Correlates in an Australian Twin Sample," *Journal of Personality and Social Psychology* 78 (2000): 524–536.

[18] N. Långström et al., "Genetic and Environmental Effects on Same-Sex Sexual Behavior," *Archives of Sexual Behavior* 39 (2010): 75–80.

[19] The phenomenon is known as "concordance-dependent ascertainment bias."

[20] L. Carter-Saltzman and S. Scarr, "MZ or DZ?" *Behavior Genetics* 7 (1977): 273–280.

[21] Ignored by researchers in the field of biological factors and homosexuality.

[22] Applying these formulas to mental habits is sometimes an amusing game more than serious science. Enter the data in the formula, and items like people's opinions on the death penalty, abortion, or the virtue of "humility" turn out to be "genetically determined" for 50 percent (N.E. Whitehead and B.K. Whitehead, *My Genes Made Me Do It!* [Lafayette LA: Huntington House, 1999]).

[23] A.C. Sandbank, *Twin and Triplet Psychology* (London/New York: Routledge, 1999).

[24] Bailey and Pillard, "Genetics of Human Sexual Orientation." I have also seen this in a few Dutch cases of SSA-discordant male twins. S.L. Farber, *Identical Twins Reared Apart* (New York: Basic Books, 1981), described two SSA-discordant female monozygotic twins who had been reared apart; the lesbian woman had a conflict-ridden relation with her foster mother and a strong attachment to her foster father, whom she imitated (not uncommon childhood factors in pre-lesbian girls).

[25] M.L. West, *The Devil's Advocate* (New York: Morrow, 1959), 104. Nicholas's erotic longings stemmed from his inferior-masculinity complex.

[26] D.H. Hamer et al., "A Linkage between DNA Markers on the X Chromosome and Male Sexual Orientation," *Science* 261 (1993): 321–327.

[27] Jerome Lejeune, letter to this author, 1993. Lejeune was the discoverer of the gene causing Down syndrome.

[28] H.S. Hu et al., "Linkage between Sexual Orientation and Chromosome Xq28 in Males but Not in Females," *Nature Genetics* 11 (1995): 248–256.

[29] G. Rice et al., "Male Homosexuality: Absence of Linkage to Microsatellite Markers at Xq28," *Science* 284 (1999): 665–667.

[30] D.H. Hamer and P. Copeland, *Living with Our Genes* (New York/London: Doubleday, 1998), 104 and 191, respectively.

[31] A. Camperio-Ciani et al., "Evidence for Maternally Inherited Factors Favouring Male Homosexuality and Promoting Female Fecundity," *Proceedings of the Royal Society of London* 271 (2004): 2217–2221. As for data collection, this was a very inaccurate study. The sample consisted of self-selected homosexual volunteers and the SSA "diagnosis" of their family members rested on their ideas about them. (Self-professed homosexual men easily project their feelings onto others.) It is true that the authors casually remark that "it is still possible" to attribute their results to "cultural rather than genetic traits," but in their whole presentation this plays no role whatever.

[32] A.F. Bogaert, "Number of Older Brothers and Sexual Orientation," *Journal of Personality and Social Psychology* 84 (2003): 644–652. Bogaert's physiological speculations have been refuted in the meantime (Gooren and Byne, "Sexual Orientation in Men and Women"). The much more plausible alternative, a psychological explanation based on the influence that the position of "sweet little brother"—*liebe Brüderchen*—has on the psychosexual development of some prehomosexual boys, was already described in 1937 by Berlin professor of psychiatry I.H. Schultz. I.H. Schultz, "Bemerkungen zu der Arbeit von Theo Lang über die genetische Bedingtheit der Homosexualität" (Notes on Theo Lang's Work on the Genetic Conditions of Homosexuality), *Zeitschrift für die gesamte Neurologie und Psychiatrie* 157 (1937): 575–578.

[33] M.S. Lasco et al., "A Lack of Dimorphism of Sex or Sexual Orientation in the Human Anterior Commissure," *Brain Research* 936 (2002): 95–98.

[34] S. LeVay, "A Difference in Hypothalamic Structure between Heterosexual and Homosexual Men," *Science* 253 (1991): 1034–1037.

[35] W. Byne et al., "The Interstitial Nuclei of the Human Anterior Hypothalamus," *Hormones and Behavior* 40 (2001): 86–92.

[36] W. Byne, letter to this author, July 2005.

[37] Byne et al., "The Interstitial Nuclei of the Human Anterior Hypothalamus," 90.

[38] I. Savic and P. Lindström, "PET and MRI Show Differences in Cerebral Asymmetry and Functional Connectivity between Homo- and Heterosexual Subjects," *PNAS* 105 (2008), http://www.pnas.org/cgi/doi/10.1073/pnas.0801566105.

[39] It should be ruled out, too, that this speculative physical peculiarity would be an effect of SSA (of a homosexual life style, drug abuse, venereal diseases, AIDS, or medicine) instead of a cause or direct predisposition.

[40] Dante, *Inferno*, XV, v. 114.

[41] Bailey and Pillard, "A Genetic Study of Male Sexual Orientation"; Bailey et al., "Heritable Factors Influence Sexual Orientation in Women."

[42] By far the most studies are about homosexual men: K. Freund, *Die Homosexualität beim Mann* (*Homosexuality in the Male*) (Leipzig: Hirzel Verlag, 1963); G.J.M. van den Aardweg, "Parents of Homosexuals: Not Guilty?" *American Journal of Psychotherapy* 38 (1984): 180–189. Van den Aardweg, *On the Origins and Treatment of Homosexuality*, reviewed 11 studies comparing male homosexuals with heterosexuals on this factor (pp. 78–80) and 4 for females (p. 181); S.L. Hockenberry and R.E. Billingham, "Sexual Orientation and Boyhood Gender Conformity," *Archives of Sexual Behavior* 16 (1987): 475–487; J.M. Bailey and K.J. Zucker, "Childhood Sex-Typed Behavior and Sexual Orientation," *Developmental Psychology* 31 (1995): 43–55; Bailey et al., "Genetic and Environmental Influences" (a review); G. Rieger et al., "Sexual Orientation and Childhood Gender Nonconformity," *Developmental Psychology* 44 (2008): 46–58. Significantly, the methods of research vary, but the outcome is always the same. Gender nonconformity in pre-lesbian girls (as set against pre-heterosexual girls) is also well documented. E.g., R.H. Gundlach and B.F. Riess, "Self and Sexual Identity in the Female," in *New Directions in Mental Health*, ed. B.F. Riess (New York: Grune & Stratton, 1968); N.L. Thompson et al., "Parent-Child Relationships and Sexual Identity in Male and Female Homosexuals and Heterosexuals," *Journal of Consulting and Clinical Psychology* 41 (1975): 120–127; E.S. Sbardelini and E.T. Sbardelini, *Homossexualismo masculino e homossexualismo feminino*, unpublished research report (Campinas SP [Brazil]: Catholic University of Campinas, Department of Psychology, 1977) (Brazilian sample); A.P. Bell et al., *Sexual Preference* (Bloomington, IN: Indiana University Press, 1981); S. Oldham et al., "Sex Role Identity of Female Homosexuals," *Journal of Homosexuality* 8 (1982): 41–46.

[43] Many male SSA groups have elevated scores on femininity in questionnaires such as the Masculinity-Femininity (Mf) scale of the Minnesota Multiphasic Personality Inventory (MMPI) and the I scale—tender-mindedness scale—of Cattell's 16 Personality Factor Test (*Handbook of the Sixteen Personality Factor Questionnaire*). See W.T. Doidge and W.H. Holtzman, "Implications of Homosexuality among Air Force Trainees," *Journal of Consulting Psychology* 24 (1960): 9–13; R.B. Dean and H. Richardson, "Analysis of MMPI Profiles of Forty College-Educated Overt Male Homosexuals," *Journal of Consulting Psychology* 28 (1964): 483–486; G.J.M. van den Aardweg, *Homofilie, neurose en dwangzelfbeklag* (*Homophilia, Neurosis and the Compulsive Tendency to Self-Pity*) (Amsterdam: Polak & van Gennep, 1967); W.A. Oliver and D.L. Mosher, "Psychopathology and Guilt in Heterosexual and Subgroups of Homosexual Reformatory Inmates," *Journal of Abnormal Psychology* 73 (1968): 323–329; R.B. Cattell and J.H. Morony, "The Use of the 16 PF in Distinguishing Homosexuals, Normals, and General Criminals," *Journal of Consulting Psychology* 26 (1962): 531–540; R.B. Evans, "Sixteen Personality Factor Questionnaire Scores of Homosexual Men," *Journal of Consulting and Clinical Psychology* 34 (1970): 212–215; M.P. Feldman and M.J. McCulloch, *Homosexual Behavior, Therapy and Assessment* (Oxford: Pergamon Press, 1971). Lesbians tend to have relatively high scores on masculinity, but on average not extremely high. Bell et al. (*Sexual Preference*) report a correlation of .53 between lesbianism and childhood/adolescent gender nonconformity. One third of a large nationwide U.S. sample of SSA women considered themselves "more feminine than masculine," one third "a little of both," and one third

"more masculine than feminine" (Gundlach and Riess, "Self and Sexual Identity in the Female").

[44] Between 2 percent and 8 percent (G.A. Westwood, *A Minority* (London: Longmans & Green, 1960); I. Bieber et al., *Homosexuality* (New York: Basic Books, 1962); van den Aardweg, *On the Origins and Treatment of Homosexuality*).

[45] Hockenberry and Billingham, "Sexual Orientation and Boyhood Gender Conformity," 485, emphasis added; the same is valid for pre-lesbian girls.

[46] See note 42 above for references.

[47] In 1932, German professor of psychiatry H. Schultz-Hencke identified the core personality trait of homosexual and pre-homosexual men as "non combativeness" ("nicht kämpferisch"). H. Schultz-Hencke, "Über Homosexualität" (On Homosexuality), *Zeitschrift für die gesamte Neurologie und Psychiatrie* 140 (1932): 300–312.

[48] Two percent, as computed from the statistics of Gundlach and Riess, "Self and Sexual Identity in the Female"; six percent according to Bailey and Zucker, "Childhood Sex-Typed Behavior"; Rieger et al., "Sexual Orientation and Childhood Gender Nonconformity." This is one of the arguments against irresponsibly stigmatizing gender nonconforming children as "gay"; they have enhanced chances of developing SSA, but this condition may not be regarded as more or less habitual before young adulthood. Even extreme sissyness in boys does not automatically lead to homosexual interests in at least 30 percent of the cases (R. Green, *The "Sissy Boy Syndrome" and the Development of Homosexuality* (New Haven CT: Yale University Press, 1987).

[49] E.g., lesbians may depict themselves as "strong," "independent," "autonomous" (e.g., J.H. Hopkins, "The Lesbian Personality," *British Journal of Psychiatry* 115 [1969]: 1433–1436; Oldham et al., "Sex Role Identity of Female Homosexuals"); as physically daring or "not avoiding fights" in childhood/adolescence (Thompson et al., "Parent-Child Relationships and Sexual Identity"; Sbardelini and Sbardelini, *Homossexualismo masculino e homossexualismo feminino*). They often were unhappy with their first menstruation (Gundlach and Riess, "Self and Sexual Identity in the Female," Table 5). But only one third felt more masculine than feminine (cf. note 38).

[50] Bieber et al., *Homosexuality*. There is ample subsequent confirmation (cf. note 42 above).

[51] Gundlach and Riess, "Self and Sexual Identity in the Female," 222.

[52] For a survey: van den Aardweg, *On the Origins and Treatment of Homosexuality* (Tables 13.1 and 27.5). Deficient bonding with father averages about 80 percent for cases of male SSA, a form of maternal over-influence about two thirds at least, and the two factors combined about 60 percent. Deficient bonding with mother averages 70 percent in female cases, mostly in the absence of a good father relationship. These are undifferentiated generalizations, though, which do not describe the multiform individual reality. Since most data come from questionnaire studies, they are subject to subjective coloration as well as blind spots on the part of the interviewee regarding his family background. For example, not all male subjects with SSA are aware of maternal overindulgence or spoiling. Traumatizing parental attitudes to the contrary tend to be overemphasized.

[53] Because she had (several) boys already, or because the girl before him had died when he was young or before his birth, or was aborted (as happened in the case of a former client of mine).

[54] Young homosexual military conscripts in Taiwan were thought to have had more overprotecting/controlling fathers and less affectionate mothers than hetero-controls (F.-W. Lung and B.-Ch. Shu, "Father-Son Attachment and Sexual Partner Orientation in Taiwan," *Comprehensive Psychiatry* 48 [2007)]: 20–26). The questionnaire used to assess parent-child relations is, however, too shoddy—the relevant questions not being asked—to take this outcome seriously.

[55] For example, Brazil (Sbardelini and Sbardelini, *Homossexualismo masculino e homossexualismo feminino*). But also in a non-Western culture such as Japan, the classic Western parental factors seem to predispose to homosexuality. Witness the case of the notorious writer Yukio Mishima (H.S. Stokes, *The Life and Death of Yukio Mishima* [New York: Scooper Square Press, 1999]). Even in a primitive tribe such as the Sambia of New Guinea, the (only) man identified as a homosexual was characterized by the familiar background factors: a neurotic man, brought up by his mother as her only child, without a father, and in a situation of pronounced peer isolation (R.J. Stoller and G.H. Herdt, "Theories of Origins of Male Homosexuality," *Archives of General Psychiatry* 42 [1985]: 399–404).

[56] As when the wife felt superior to her husband, and dominated him and her family, or when the husband was a womanizer or had a drinking problem. Serious marriage problems marked 60 percent of the parents of socially adapted men with SSA (R. Liddicoat, "Homosexuality," *British Medical Journal* 9 [1957]: 1110–1111), more than parents of neurotic controls (Bieber et al., *Homosexuality*).

[57] Well-documented since S. Glueck and E.T. Glueck, *Unraveling Juvenile Delinquency* (Cambrige MA: Harvard University Press, 1950).

[58] It is well known that about two thirds of black American teens grow up without their father. Bieber et al., *Homosexuality*, found the combined parental pattern most characteristic for men with SSA and in 20 percent of neurotic controls.

[59] For example, 36 percent of 121 male cases (van den Aardweg, *On the Origins and Treatment of Homosexuality*).

[60] See, e.g., W.G. Stephan, "Parental Relationships and Early Social Experiences of Activist Male Homosexuals and Male Heterosexuals," *Journal of Abnormal Psychology* 82 (1973): 506–513: the experiences occurred in 75 percent of his male sample.

[61] Recollections of rejection and teasing are subjective. Although in some cases the memories correspond more to the reality of the past than in other ones, these people may have been affected by self-dramatization or self-victimization. Also, sometimes teasing was provoked by the child's irritating behavior (e.g., spoiled-child manners, obtrusive attention seeking). Children and youngsters mostly do not see their own role in this.

[62] For men, at about fifteen years (J. Loney, "Background Factors, Sexual Experiences, and Attitudes Towards Treatment in Two 'Normal' Homosexual Samples," *Journal of Consulting and Clinical Psychology* 38 [1972]: 57–65); between ten and seventeen years, peaking at age thirteen to fourteen (van den Aardweg,

On the Origins and Treatment of Homosexuality). For women, mostly after the onset of puberty (Gundlach and Riess, "Self and Sexual Identity in the Female").

[63] Alfred Adler, "Das Problem der Homosexualität" (The Problem of Homosexuality), in *Zeitschrift der Individualpsychologie* (1917; Leipzig: Hirzel, 1930), was the first to point to the basic gender-inferiority complex of homosexuals, which was a fundamental step forwards in our understanding of the syndrome.

[64] The relation between enduring inferiority feelings (that is, an inferiority complex) and self-dramatization in the case of homosexuality was first described by Dutch psychiatrist Johan Arndt, in "Een bijdrage tot het inzicht in de homoseksualiteit" (A Contribution to the Understanding of Homosexuality), *Geneeskundige Bladen* 3 (1961): 65–105.

[65] D.P. McWhirter and A.M. Mattison, *The Male Couple* (Englewood Cliffs, NJ: Prentice Hall, 1984) (the few "faithful" same-sex partnerships in males lasted 5 years at most); M. Dannecker, *Homosexuelle Männer und AIDS* (*Homosexual Men and AIDS*) (Stuttgart: Kohlhammer, 1990); A.A. Deenen et al., "Intimacy and Sexuality in Gay Male Couples," *Archives of Sexual Behavior* 23 (1994): 421–431 (average number of outside partners in first year of steady relations was 2.5, in sixth year 11); M. Xiridou et al., "The Contribution of Steady and Casual Partnerships to the Incidence of HIV Infection among Homosexual Men in Amsterdam," *AIDS* 17 (2003): 1009–1038 (steady male partnerships average 1.5 years); R.M. Grant et al., "Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men," *New England Journal of Medicine* 363 (2010): 2587–2599 (HIV-negative SSA and transsexual men average eighteen partners every three months). Lesbian partnerships are more stable, but less so than unstable relations of heterosexual women (P. Blumstein and P. Schwartz, *American Couples* [New York: Morrow, 1983]).

[66] The so-called "homo monument" in Amsterdam, meant to celebrate the gay emancipation, contains this dramatic, but psychologically correct exclamation by Dutch homosexual poet Jacob Israel de Haan: "For friendship, such a boundless longing. . . ."

[67] "Drinking salt water," the German gay designer Joop Wolff called his sex addiction.

[68] The gay subculture is psychologically pubescent. Only 10 percent of men with SSA prefer a partner above age forty. It is of note that this does not necessarily mean that these men seek a father. Some indeed want to be protected by an older partner in a fatherly way, but the older man seems above all to be the masculine idol of their adolescence: a sailor, a soldier, and the like. They adored this type for having what they felt wanting in themselves (Statistics: H. Giese, *Der homosexuelle Mann in der Welt* (*The Homosexual Man in the World*) [Stuttgart: Enke, 1958]; Freund, *Die Homosexualität beim Mann*; A. Zebulon et al., "Sexual Partner Age Preferences of Homosexual and Heterosexual Men and Women," *Archives of Sexual Behavior* 29 [2000]: 67–76).

[69] Gundlach and Riess, "Self and Sexual Identity in the Female," 226.

[70] R. Friedman and L. Stern, "Juvenile Aggressivity and Sissiness in Homosexual and Heterosexual Males," *Journal of the American Academy of Psychoanalysis* 8 (1980): 432–433.

[71] N. Whitehead and B. Whitehead, *My Genes Made Me Do It: Homosexuality and the Scientific Evidence* (Lower Hutt, New Zealand: Whitehead Associates, 2010), http://www.mygenes.co.nz/MGMMDIInfo.htm, refer to several supportive studies (p. 257).

[72] H.J. Eysenck and S.B.G. Eysenck, *Manual of the Eysenck Personality Inventory* (London: University of London Press, 1965). A vast body of research underlies the notion of neuroticism as one of the few basic dimensions of personality and the subsequent construction and validation of neuroticism (N) tests; most work was done by the schools of Hans Eysenck (London) and Raymond Cattell (Chicago).

While it is true that N inventories are the best measuring instruments for neurotic tendencies, they can, however, be faked, and are not immune to simulation as well as dissimulation.

[73] R.B. Cattell and G.F. Stice, *Handbook of the Sixteen Personality Factor Questionnaire* (Champaign, IL: Institute for Personality and Ability Testing, 1957).

[74] G.J.M. van den Aardweg, in "Male Homosexuality and the Neuroticism Factor," *Dynamic Psychotherapy* 3 (1985): 79–87, and *On the Origins and Treatment of Homosexuality*, 170–173 and 188–189, reviewed 17 studies comparing homosexual with heterosexual men up to 1986, and a few comparing lesbians with controls. Homosexuals make high scores, whether they are therapy clients, self-accepting, or militantly gay, and independent of nation or culture. Curiously, it seems that this line of study dried up afterwards, with a few exceptions (e.g., Lung and Shu, "Father-Son Attachment," young Taiwanese men with SSA scored much higher than two heterosexual control groups).

[75] M.S. Weinberg and C.J. Williams, *Male Homosexuals* (New York: Oxford University Press, 1974). Men with SSA from cultures with varying degrees of homosexuality tolerance (U.S., Denmark, Holland) did not differ as to psychoneurotic symptoms. There is no evidence either that socially discriminated groups such as blacks make high N scores. Blacks report more physical health problems than whites, but as many or slightly less mental health symptoms (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, "1996 National Household Survey of Drug Abuse," as analyzed by P. Cameron et al., "Homosexual Sex as Harmful as Drug Abuse, Prostitution or Smoking," *Psychological Reports* 96 [2005]: 915–961).

[76] T.G.M. Sandfort et al., *Sexual Orientation and Mental Health* (Stony Brook, NY: International Academy of Sex Research, 1999); D.M. Fergusson et al., "Is Sexual Orientation Related to Mental Health Problems and Suicidality in Young People?" *Archives of General Psychiatry* 56 (1999): 876–880 (a birth cohort followed up until age 21); R. Herrell et al., "Sexual Orientation and Suicidality," *Archives of General Psychiatry* 56 (1999): 867–874 (increased suicide risk in homosexual twins with a heterosexual co-twin, related to depression).

[77] Statistics: A.P. Bell and M.S. Weinberg, *Homosexualities* (New York: Simon & Schuster, 1978), 457; Gundlach and Riess, "Self and Sexual Identity in the Female," 225. Further confirmation: S.D. Cochran and V. Mays, "Lifetime Prevalence of Suicide Symptoms and Affective Disorders among Men Reporting Same-Sex Sexual Partners," *American Journal of Public Health* 90 (2000): 573–578; M. King et al., "Mental Health Quality of Life of Gay Men and Lesbians in England and Wales," *British Journal of Psychiatry* 83 (2003): 552–558; and

Fergusson et al., "Is Sexual Orientation Related to Mental Health Problems"; and S.T. Russell and K. Joyner, "Adolescent Sexual Orientation and Suicide Risk," *American Journal of Public Health* 91 (2001): 1276–1281, for adolescents.

[78] Cf. note 65 above.

[79] McWhirter and Mattison, *The Male Couple*: 43 percent of the cases; and 60 percent masturbated two to three times per week.

[80] P. Cameron, "Domestic Violence among Homosexual Partners," *Psychological Reports* 93 (2003): 410–416, (a review).

[81] Cameron et al., "Homosexual Sex as Harmful as Drug Abuse."

[82] I know no exception to this rule.

[83] Cf. Lombroso's theory of the "delinquente nato," the born-that-way delinquent.

[84] The homosexual pedophile, whose fantasies concern children who do not yet display the secondary sexual signs, felt excluded from the boyhood (not the adolescent) community, which sparked his fascination for typical boyish traits. (Lesbian pedophilia is much rarer.)

[85] There is reason to include a substantial number of transsexuals in the category of "homosexuality" (J.M. Bailey, *The Man Who Would Be Queen* [Washington, D.C.: Joseph Henry Press, 2003]). Transsexual men do not differ from non-transsexual homosexual males in parental background factors (e.g., K. Freund et al., "Parent-Child Relations in Transsexual and Non-Transsexual Homosexual Males," *British Journal of Psychiatry* 124 [1974]: 22–23), and there are marked similarities both in their childhood/teenage self-view and promiscuous sexuality (Grant et al., "Preexposure Chemoprophylaxis").

[86] R.P. Fitzgibbons, "The Origins of Same-Sex Attraction Disorder," in *Homosexuality and American Public Life*, ed. Chr. Wolfe (Chicago, IL: Spence, 1999).

[87] Van den Aardweg, *Homofilie, neurose en dwangzelfbeklag* (drawing on Arndt, "Een bijdrage tot het inzicht"). Inner self-dramatization explains the aptitude of indignant gay activists to further their cause of social normalization by presenting themselves as victims of inhumane "homophobia" and rejection. However, although it may seem that their dramatized self-view of rejection results from non-acceptance because of their homosexuality, it actually traces back to their traumatic not-belonging to the childhood/adolescent same-sex world, which preceded and provoked their orientation. On the other side, if their sexuality were completely recognized socially, their complaining about being slighted and maltreated would not stop.

[88] E. Bergler, *Homosexuality: Disease or Way of Life?* (New York: Hill & Wang, 1957). These several notions—"unresolved anger," "self-pity/self-victimization," "injustice collecting"—largely overlap. The reader may recall the complaints of Nicholas Black, which exemplify this mixture of self-victimization, bitterness, and injustice collecting.

[89] E. Bergler, *Counterfeit Sex* (New York: Grune & Stratton, 1958).

[90] For example, Alan Medinger, *Growth into Manhood* (Colorado Springs, CO: Waterbrook Press, 2000); for an ex-lesbian woman, recognizing her being "not grown up at all" was the start of a complete and lasting cure (G.J.M. van den Aardweg, "A Completely Cured Lesbian," in idem, *Homosexuality and Hope* (Ann Arbor, MI: Servant Publications, 1985), 91–95.

[91] In some cases it cannot be far from the truth to assume that the person's sexual and other self-directed drives are literally "demonized," i.e., came into the power of a demon. Since demons can blow on passions and stir up fantasies and selfish inclinations (J.-B. Scaramelli, *Regeln zur Unterscheidung der Geister* (*Rules for Distinguishing the Spirits*), ed. W. Schamoni [c. 1740; Abensberg, Germany: Josef Kral, 1975]), it is rather certain that they are involved in the growth and maintenance of sexually abnormal obsessions such as homosexuality.

[92] R.L. Spitzer, "Can Some Gay Men and Lesbians Change Their Sexual Orientation?" *Archives of Sexual Behavior* 32 [2003]: 403–417, examining 200 "ex-gays," found 11 percent of the men "completely changed" (from homo- to heterosexuality) according to strict criteria (29 percent according to more lenient criteria), and 37 percent (or 63 percent) of the women. Twenty-six percent of the men and 49 percent of the women were "not at all bothered" any more by homosexual desires, and 62 percent of the men (46 percent of the women) only "slightly." The average follow-up period was 12 years. This author reported that of 100 male ex-clients 43 percent stopped treatment within a couple of months, 11 percent had changed radically, 26 percent satisfactorily, 11 percent had improved, 9 percent were unchanged (average follow-up two to three years post-treatment; van den Aardweg, *On the Origins and Treatment of Homosexuality*, Table 40.6).

[93] Ten percent of a recent English sample of practicing male homosexuals wished for this kind of help (King et al., "Mental Health Quality of Life"). One may get an impression of the underlying need of change-directed help from an incidental finding, as reported by Bell and Weinberg, *Homosexualities*, that between one fifth and one third of practicing male homosexuals regarded their sexuality as an emotional disorder, and that even 58 percent had sought psychological or psychiatric assistance (for unspecified reasons; Bell et al., *Sexual Preference*).

[94] G.J.M. van den Aardweg, *The Battle for Normality* (San Francisco: Ignatius Press, 1997).

[95] R.D. Enright and R.P. Fitzgibbons, *Helping Clients Forgive* (Washington, D.C.: American Psychological Association, 2000).

[96] A third of the 200 "ex-gays" examined by Spitzer, "Can Some Gay Men and Lesbians Change" (p. 407), said a religious support group had been most helpful. The Catholic apostolate *Courage*, founded by the late Fr. John Harvey, has a most practical ideal, living chastely. That seems a modest target; however, it is key in any process of change. For impurity, the cherishing of immature and selfish sensuality in behavior and fantasy life, strongly reinforces the gender-inferiority complex.

In this connection, the question may arise: what may be done to help non-believing clients/patients? In their case, the approach is largely the same because all good-intentioned people are susceptible to moral values and can see the importance of exercising the virtues and fighting the vices. Some may become more open to belief in God when struggling with their immature fixations. Others may return to the religion of their childhood. Anyhow, the best examples of long-lasting radical change I personally know are persons with a God-centered inner life.